



PROJECT REACH: Illinois Deaf-Blind Services

*Serving youth who are deaf-blind, their families,
and their schools*

Please return this form to:
Philip J. Rock Center & School
818 DuPage Blvd., Glen Ellyn, IL 60137
(630)790-2474/TTY/V(800)771-1158
FAX: (630)790-4893
Email: PRC@philiprockcenter.org

**FORM A: INITIAL REFERRAL FOR DETERMINATION OF
ELIGIBILITY FOR SERVICES**

Child's Name: _____ Date of Birth: _____

Gender: Male Female Ethnicity: Caucasian Asian African American 2 or more
 Hispanic/Latino Pacific Islander/Native Hawaiian American Indian or Alaskan Native

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ County: _____

School District/CFC: _____ Current Program/School: _____

Current Program Contact Name: _____ Phone Number: _____

Parent(s)/Caregiver(s) Name(s): _____
Mother Father

Address: _____ City: _____ State: ____ Zip: _____
(if different from above)

Home Phone: _____ Work Phone: _____

Email: _____

Primary language used in home: _____

Is there a legal guardian other than parents? Yes No

If yes... _____
Name Address City State Zip Phone Number

I hereby give permission to Project Reach: Illinois Deaf-Blind Service to determine eligibility for Project Reach service for my child. I further understand if my child is found eligible for services, that he/she will be placed on the Illinois-NCDB child count.

I acknowledge and understand that I may revoke this consent at any time, by submitting to Project Reach: Illinois Deaf-Blind Services a written, signed and dated notice stating that the consent is revoked.

Signature of parent, legal guardian Relationship to child

Date

Cause of Deaf-Blindness (if known): _____

*Vision Status (if known): _____

*Hearing Status (if known): _____

* ____ Date of the most recent vision diagnostic report.

* ____ Date of the most recent hearing diagnostic report.

Name of person submitting referral: _____

Agency: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Date: _____

Email: _____

How do you know child? _____

What do you need help with? _____

Is there anything else you would like for us to know? _____

Was the referral a result of:

_____ your receiving TA for another child?

_____ your past knowledge of Project Reach services?

_____ a recommendation by a colleague?

_____ a recommendation by another family receiving Project Reach services?

_____ attending a conference or training?

_____ receiving information about Project Reach through the mail?

_____ visiting the Project Reach Website

_____ other _____

A Deaf-Blind Specialist will be calling you to follow up on this request.
